

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014	
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 274 SS=D	<p>The following represents the findings of a Health resurvey # 63BN11 and complaint # 72094.</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This Requirement is not met as evidenced by: The facility census totaled 29 resident with 16 included in the sample with one review for comprehensive assessment. Based on observation, interview and record review the failed to complete a comprehensive assessment for a resident with a significant change.(#3)</p> <p>Findings included:</p> <p>Admission date 10/22/14</p> <p>- Review of the resident #3's comprehensive MDS (minimum data set) dated 8/31/14 revealed the resident had long term and short term memory impairment. The resident required extensive assistance with ADLs (activities of daily living). He/she was incontinent of bowel and</p>			F 274			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	<p>Continued From page 1 bladder</p> <p>Review of the CAA (care area assessment) revealed the resident did not have a CAA that had included the need for hospice.</p> <p>Review of the resident's care plan, initiated 8/28/14, revealed a new order for a hospice consult if the family wished. The residents family was making the decision. His/her family wished for him/her to have strict comfort care. The family wished for the staff to manage the resident's pain, but did not wish for any further testing.</p> <p>Review of the resident's care plan, initiated 11/12/14, revealed the residents family had chosen hospice to provide end of life care with the facility, for the resident's comfort and dignity. Staff were to observe the resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there had been breakthrough pain.</p> <p>Hospice physician order dated 11/11/14 revealed diagnosis of renal failure</p> <p>Interview with licensed nursing staff B on 12/03/2014 at 2:41 PM revealed hospice nurse talked with the charge nurse about whether or not the resident had any change. The hospice nurse was at the facility twice a week and hospice aide came twice week as well. Hospice had supplied the medication and supplies.</p> <p>Interview with administrative nursing staff B on 12/03/2014 at 7:50 AM revealed MDS significant</p>	F 274			

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F 274	Continued From page 2 change needed to have 14 days to complete an ARD (assessment review date). He/she is aware that the significant change was not completed but the care plan had been updated for. Interview with administrative nursing staff B on 12/03/2014 at 9:26 AM revealed the care plans are updated every quarter, annually, fall skin issues, antibiotic and significant change . MDS are triggered by ARD date and need to be completed within 10 days once it had been triggered. Facility failed to provide policy regarding comprehensive assessment. The facility failed to develop a comprehensive assessment for resident #3 reflecting the need for hospice services.	F 274			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279			

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F 279	<p>Continued From page 3</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 29 residents with 16 in the sample. Based on observation, interview, and record review the facility failed to develop comprehensive care plans for 2 of 16 residents. (#3 related to hospice services and #20 related to pressure ulcer care)</p> <p>- Review of resident #20's significant change MDS (Minimum Data Set) dated 1/27/14 revealed a BIMS (Brief Interview for Mental Status) score of 01, indicating severe cognitive impairment. He/she did not exhibit rejection of care. He/she required extensive assistance of 1 staff for bed mobility. He/she used a walker and wheelchair for mobility. The assessment indicated the resident had an unstageable pressure ulcer (full thickness tissue loss of a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction in which the actual depth of the wound was obscured by dead tissue) present on admission. The resident had a pressure relieving mattress and chair device, was on a turning/repositioning program, had pressure ulcer care, and a dressing to his/her feet.</p> <p>Review of resident #20's Pressure Ulcer CAA (Care Area Assessment) dated 2/10/14 revealed the resident had an actual unstageable pressure wound to the back of his/her left heel. Resident #20 returned from the hospital with the wound. Daily monitoring and weekly assessments of the wound were done. Resident #20 had a pressure relief mattress and his/her feet were off-loaded as</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>well. Resident #20 was unable to understand the potential of wounds and had decreased ability to feel pressure. Resident #20 did take antianxiety medication which could cause the resident not to be as aware of the need to move. The resident's decreased mobility and circulation difficulty could cause decreased response to pressure. His/her wound was mostly due to being in bed and friction.</p> <p>Review of the quarterly MDS dated 10/30/14 revealed a BIMS score of 01, indicating severe cognitive impairment. He/she did not exhibit rejection of care. He/she required extensive assistance of 1 staff for bed mobility. The assessment indicated the resident did not use an assistive device for mobility. The resident had an unstageable pressure ulcer on admission. The resident had a pressure relieving mattress and chair device, was on a turning/repositioning program, and had pressure ulcer care.</p> <p>Review of resident #20's care plan dated 1/30/14 revealed the resident returned from the hospital with an unstageable wound to his/her left heel. Interventions included providing treatment as ordered, heel to be off-loaded at all times, and he/she wore compression stockings for edema. The care plan was not specific to identify the types of interventions in place to ensure resident #20's heel was off-loaded.</p> <p>Review of a Braden Scale score done 10/25/13 revealed a score of 21. An interview on 12/4/14 at 11:47 a.m. with administrative nursing staff B revealed a score of 16 or less indicated the resident was at risk for pressure ulcers.</p> <p>Review of a Braden Scale score done 1/27/14 revealed a score of 19.</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>Review of a Braden Scale score done 4/29/14 revealed a score of 19.</p> <p>Review of a Braden Scale score done 10/30/14 revealed a score of 19.</p> <p>Review of a Skin/Wound Note dated 1/29/14 revealed the resident's left heel had a loose scab and dark red drainage. The area was cleansed, patted dry and an off-load dressing was applied. The area measured 1 cm (centimeter) by 1.5 cm with irregular wound edges. The surrounding skin was pink, warm, and dry.</p> <p>During an observation on 12/2/14 from 3:00 p.m.-4:30 p.m. resident #20 sat in the recliner in his/her room with the footrest in the up position and his/her feet hung off the edge of recliner.</p> <p>During an observation on 12/3/14 at 7:28 a.m. resident #20 rested on his/her back while in bed. At 7:46 a.m. direct care staff H entered the resident's room and uncovered his/her lower body, resident #20's heels were resting on the bed and not off-loaded. Resident #20's left heel had an area of brown-purple discoloration approximately 2 cm by 2 cm with dry skin. At 8:59 a.m. the resident sat in his/her recliner in his/her room with his/her footrest in the up position with his/her heels hanging off the foot rest.</p> <p>During an interview on 12/3/14 at 9:37 a.m. direct care staff J reported resident #20 had an area on his/her left foot, but he/she was unsure if the area was a pressure ulcer. Staff J reported the resident had some kind of cushion to lift his/her heels off the bed used at night while in bed. Staff J reported while the resident sat in the recliner the staff ensured his/her feet rested off the</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>footrest. Staff J confirmed on the kardex (electronic care plan accessible to the aides) the resident's heels were to be off-loaded at all times, but it did not identify the specific interventions of the boot, cushion, or ensuring the resident's heels did not rest on the footrest of the recliner.</p> <p>During an interview on 12/3/14 at 2:27 p.m. direct care staff I reported resident #20 wore a boot on his/her left foot at night and his/her feet were propped up with heels off the bed with a pillow folded in half. Staff I reported while the resident was in the recliner his/her footrest was in the up position and his/her feet were to hang off the edge. He/she reported he/she also encouraged the resident to ambulate to prevent pressure. Staff I reported he/she thought the interventions in place for the resident's left heel pressure ulcer were on the care plan. At 2:50 p.m. staff I confirmed the kardex identified resident #20's left heel was to be off-loaded at all times, but it did not state the specific interventions.</p> <p>During an interview on 12/3/14 at 3:53 p.m. licensed nursing staff E reported resident #20 had a pressure ulcer to his/her left heel that was almost healed. Staff E reported interventions included to off-load the heel with a boot in place at night while in bed, positioning the feet with no points of pressure while in the chair, wheelchair, and bed. Staff E reported the staff put a pillow under the resident's legs while in bed. He/she confirmed the care plan stated to off-load resident #20's heels at all times, but did not identify the specific interventions in place for the left heel. During an interview on 12/4/14 at 11:47 a.m. administrative nursing staff B revealed resident #20's left heel was monitored and was to be off-loaded. He/she reported the resident had a left heel boot he/she was to wear. Staff E reported</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>the comprehensive care plan indicated the resident's heel was to be off-loaded at all times. Staff E confirmed the interventions of left foot boot needed to be on the care plan.</p> <p>Review of the facility's policy for Comprehensive Care Plans dated 07/2001 revealed the facility developed a comprehensive care plan for each resident that included measurable objectives and a timetable to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. The care plan was developed according to regulations by an interdisciplinary team to the extent practicable.</p> <p>The facility failed to develop a comprehensive care plan that identified interventions to care for resident #20's left heel pressure ulcer and prevent the development of additional heel ulcers.</p> <p>- Review of the resident #3's comprehensive MDS (minimum data set) dated 8/31/14 revealed resident had long term and short term memory impairment. The resident required extensive assistance with two staff members for ADLs (activities of daily living). He/she is incontinent of bowel and bladder</p> <p>Review of the resident's care plan, initiated 8/28/14, revealed a new order for a hospice consult if the family wished. The residents family was making the decision. His/her family wished for him/her to have strict comfort care. The family wished for the staff to manage the resident's pain, but did not wish for any further testing.</p> <p>Review of the resident's care plan, initiated</p>	F 279			

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F 279	<p>Continued From page 8</p> <p>11/12/14, revealed the residents family had chosen hospice to provide end of life care with the facility, for the resident's comfort and dignity. Staff were to observe the resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there had been breakthrough pain.</p> <p>Review of the resident's care plan revealed the care plan did not describe the services that are to be furnished by hospice to attain and maintain well being.</p> <p>Review of the Social Services Progress Note dated 11/19/14 at 1:39 p.m. revealed the staff held a Care Plan meeting for the resident. None of the family came to the care plan meeting. The resident was being admitted to hospice it had been discussed with family.</p> <p>Observation on 12/02/14 at 3:01 PM revealed the resident was resting in recliner with oxygen on and covered with blanket.</p> <p>Observation on 12/03/14 at 8:58 AM revealed hospice aide there to give resident a shower.</p> <p>Interview with direct care staff K on 12/4/14 at 10:03 AM revealed resident received baths on Tuesay and Thursdsay from hospice. The facility would provided baths on Monday and Wednesday. The hospice brought the supplies for resident #3. Staff did not know when hospice had been in the facility. The staff was unaware where to look and see where hospice was to be in the facility to provide care.</p> <p>Interview with direct care staff I on 12/03/14 at 3:30 pm hospice provide the briefs, wipes. Staff</p>	F 279			

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F 279	<p>Continued From page 9</p> <p>do not know when hospice has been there sometime hospice has been there on first or second. The nurse sometime let staff know when they had been there. The careplan just listed resident had been receiving hospice and not list what hospice was providing. Staff was unable to determine what service hospice was providing when reviewing the care plan.</p> <p>Interview with direct care staff H on 2/03/14 at 9:10 AM revealed that hospice came out twice a week to give showers and then the days have been changed.</p> <p>Interview with licensed nursing staff E on 12/03/2014 at 2:41 PM revealed hospice nurse talked with the charge nurse about any change with resident. The hospice nurse came to the facility twice a week and hospice aide came twice a week. Staff revealed that hospice supplied the medication and supplies.</p> <p>Interview with administrative nursing staff B on 12/03/2014 at 9:26 AM revealed he/she would put what the hospice services are provided and whether or not hospice provide medication and supplies. He/she would care plan how often hospice comes in the facility to provide care for example baths. The care plans need to be updated every quarter, annual, fall skin issues, antibiotic and significant change.</p> <p>Review of the facility policy for comprehensive care plans, last revised 7/7/2001, revealed the facility will develop a comprehensive care plan for each resident that includes measureable objectives and timetable to meet a resident's medical, nursing and mental and psychosocial needs that are identifies in the comprehensive</p>	F 279			

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F 279	Continued From page 10 assessment.	F 279			
F 280 SS=E	<p>Facility failed to provide a clear comprehensive care plan that revealed what type of services hospice are to provide and to inform staff on the type of care provided.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This Requirement is not met as evidenced by: The facility's census totaled 29 with residents in the sample. Based on record review and interview the facility failed to ensure that resident care plans were revised in a timely manner following significant changes or events (#12, for nutrition and pressure ulcers, and #4, #16, and #21 for accidents).</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>Findings Included:</p> <ul style="list-style-type: none"> - Review of resident # 16's diagnoses from the physician's order sheet dated 10/14/14 revealed multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), spasm of muscle, and muscle weakness. <p>Review of resident # 16's annual MDS (Minimum Data Set) dated 11/22/13 revealed the resident had a BIMS (brief interview of mental status) score of 15 which indicated no cognitive impairment. The resident required one person extensive assistance for bed mobility, transfers, personal hygiene, and dressing, and two person assistance for toileting. The resident was independent for eating and locomotion. The resident used a wheel chair for locomotion. The resident had one non injury fall since the last assessment.</p> <p>Review of the quarterly assessment MDS dated 08/25/14 revealed the resident had a BIMS score of 15 which indicated no cognitive impairment. The resident required one person extensive assistance for bed mobility, transfers, and personal hygiene, and two person assistance for dressing. The resident was totally dependent on 2 people for toileting. The resident was independent for eating and locomotion. The resident used a wheel chair for locomotion. The resident had no falls since the last assessment.</p> <p>Review of the ADL (activities of daily living) CAA (Care Area Assessment) dated 12/5/13 revealed the resident took antidepressants which could add to difficulties in transfers. The resident required total lift with transfers and had increased</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
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F 280	<p>Continued From page 12</p> <p>weakness. The resident had an increased potential for falls. The resident had to have assistance of two persons to transfer to the toilet.</p> <p>Review of the fall CAA dated 12/06/13 revealed the resident had the potential for falls. The resident had weakness and needed assistance with all transfers. The resident had falls in the past, typically from reaching or dozing off and sliding from his/her chair. The resident was unable to sit well without support.</p> <p>Review of the Care Plan dated 09/03/14 revealed the resident was at moderate risk for falls related to MS, muscle spasms, and muscle weakness. The staff was to assist the resident for all transfers. The staff were to anticipate needs and make sure the call light was within reach. For transfers 2 staff would participate for toilet use, 1 staff for other transfers. The resident preferred not to wear shoes and wears socks only. The resident used 2 cushions on his/her wheelchair. The care plan did not reveal any revisions after the fall on 11/3/14.</p> <p>Review of the nursing note dated 11/3/14 at 7:53 PM revealed the resident's legs gave out as a CNA (Certified Nurse Aide) transferred him/her. The cushion in his/her wheel chair slid out and the resident and the staff both fell together.</p> <p>Review of the fall investigation report dated 11/3/14 revealed a CNA assisted the resident with a transfer and the resident's legs gave out and the cushion in the wheel chair slid out. Both the CNA and the resident slid to the floor. The resident denied hitting his/her head or injury. Staff assessed the resident and vital signs were obtained. Staff transferred the resident into his/her wheel chair and the resident was able to</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 13</p> <p>assist with weight bearing. The resident was oriented. Factors that staff identified as having influenced the fall were; the resident was incontinent and had a diagnosis of MS which was worsening, and the resident had a pressure relieving cushion that was oversized and slid out during the transfer. The administrator, DON (director of nursing), and physician were notified promptly.</p> <p>Review of the nursing notes dated 11/03/14 revealed there were no injuries to the resident and the vital signs were within normal limits. Staff placed a new cushion in the resident's wheel chair.</p> <p>An interview with the resident on 12/02/14 at 4:58 PM revealed he/she required assistance with transfers and that he/she never attempted it without staff present.</p> <p>During an interview on 12/03/14 at 12:00 PM with direct care staff F revealed the resident transferred with a gait belt and pivoted on his/her own. Toileting required 2 staff to assist the resident with transferring, otherwise one staff could transfer the resident if he/she used a gait belt. The resident never got up on his/her own and always used the call light appropriately. The staff interventions were to answer the call light quickly, and use a gait belt. The resident required cushions in his/her wheel chair due to skin breakdown and when he/she fell there were 2 cushions and they slid. After the fall the staff changed the wheelchair cushion to one large cushion.</p> <p>During an interview on 12/03/14 at 3:40 PM with nursing staff E revealed the resident fell during transfer and slid out of the wheel chair. The</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
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F 280	<p>Continued From page 14</p> <p>resident required one staff for transfers and 2 for toileting. The resident now has just one thick cushion and had 2 at the time of the fall. The resident had not had any other falls. With a fall the nurse would perform the route cause analysis to figure out if the fall could be prevented. The nurse would add new interventions to the care plan if necessary following an investigation. The care plans were evaluated by the nurse and DON.</p> <p>During an interview on 12/4/14 at 12:24 PM with administrative nursing staff B revealed the care plan should have been updated after the fall on 11/03/14 to reflect the current interventions.</p> <p>Review of the facility's policy Comprehensive Care Plans, dated 07/07/2001 revealed resident care plans would be reviewed every 90 days and if the resident experienced a significant change in physical condition.</p> <p>The facility failed to review and revise resident # 16's care plan after his/her fall on 11/03/14.</p> <p>- Review of resident #12 's signed physician 's order sheet dated 10/13/14 revealed the following diagnoses: esophageal reflux (backflow of stomach contents to the esophagus).</p> <p>Review of the admission MDS (Minimum Data Set) dated 5/29/14 revealed a BIMS (brief interview of mental status) score of 8 which indicated moderate cognitive impairment. The resident required limited assistance of 1 staff for</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 15</p> <p>eating. The resident had loss of liquids/solids from his/her mouth when eating or drinking, and coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain when swallowing. The resident had a mechanically altered diet, and required a change in texture of food or liquids.</p> <p>Review of the cognitive loss CAA dated 5/29/14 revealed the resident had some cognitive deficit and required cueing and time to answer. The resident had been cognitively intact during the previous assessment and needed assistance adjusting to change. The resident did have total dependence on staff for much of his/her ADL (activities of daily living) care.</p> <p>Review of the nutritional CAA dated 5/29/14 revealed the resident was overweight. At the time of the assessment the physician did not put the resident on a diet. The resident had swallowing difficulties and was being seen by speech therapy. The resident was on a pureed diet with honey thickened liquids. The resident had a CVA (Cerebrovascular accident - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) resulting in right sided hemiparesis (muscular weakness or partial paralysis restricted to one side of the body). The resident required assistance and monitoring with meals.</p> <p>Review of the significant change MDS dated 10/6/14 revealed the resident had a BIMS score of 14 which indicated cognitively intact. The resident required staff supervision/set up for meals. The assessment revealed he/she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The resident was not on a prescribed weight-loss</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
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F 280	<p>Continued From page 16 regimen.</p> <p>Review of the resident ' s care plan last revised 06/06/14 revealed the resident had difficulty swallowing due to right side hemiparesis, and staff were to monitor for choking. The resident was to avoid lying down for at least 1 hour after eating and staff were to keep head of the bed elevated and encourage the resident to stand upright after meals. Staff were to assist the resident to avoid foods or beverages that tended to irritate the esophageal lining such as; alcohol, chocolate, caffeine, acidic or spicy foods, and fried or fatty foods. All staff were to be informed of the resident ' s special dietary and safety needs. The resident took the medications Omeprazole, and Reglan for gastric reflux prevention. An intervention to the care plan was added on 9/16/14 that indicated the resident could have regular foods. Staff were to notify the charge nurse if the resident exhibited choking. An intervention to the care plan was added on 11/20/14 that indicated the resident should receive Boost supplement shakes three times daily.</p> <p>The facility failed to add any interventions for weight loss after the weight decrease on 6/27/14, and failed to place health shakes on the care plan after the 6/23/14 orders.</p> <p>Review of the physician orders dated 6/23/14 revealed the resident should receive a regular diet with puree consistency and honey thickened liquids.</p> <p>Review of the physician orders dated 6/23/14 revealed the resident was to have health shakes three times daily.</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 17</p> <p>Review of the physician orders dated 9/18/14 revealed the resident ' s diet changed to a regular diet with pureed texture and thin liquids.</p> <p>Weight loss from 6/27 to 7/23 totaled 9.2% loss of the resident ' s body weight in one month.</p> <p>Interview on 12/04/2014 at 10:23 AM with licensed nursing staff E revealed if a resident had a weight loss the resident would be seen by the physician, and it would be included in the care plan meetings.</p> <p>Interview on 12/04/2014 at 11:23 AM with administrative nursing staff B revealed the facility did not do any preventative care for residents to prevent weight loss. Staff B was aware of the weight changes for resident # 12. Staff B reported he/she was responsible for monitoring the residents ' weights and updating the care plans, as well as implementing interventions for weight loss.</p> <p>An interview on 12/04/14 at 5:00 PM with dietary management staff D revealed he/she assisted with the tracking of the resident ' s weights. A change of 2-3% in weight would be reported to the Director of Nursing. He/she verified that no supplements had been placed on the care plan until recently and that the nursing staff gave supplements.</p> <p>Review of the facility's policy Comprehensive Care Plans, dated 07/07/2001 revealed resident care plans would be reviewed every 90 days and if the resident experienced a significant change in physical condition.</p> <p>The facility failed to review and revise resident # 12 ' s care plan after weight loss had been identified on 6/27/14. The facility also failed to</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 18</p> <p>add the ordered nutritional supplements to the resident ' s care plan.</p> <p>- Review of resident #4 ' s annual MDS (Minimum Data Set) dated 3/29/14 revealed a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. He/she did not exhibit rejection of care. He/she required extensive assistance of 1 staff for bed mobility. He/she required limited assistance for transfers, walking in the room/corridor, and locomotion on/off the unit. He/she did not have a steady balance, but was able to stabilize without staff assistance. He/she utilized a walker for mobility. The assessment indicated the resident had 1 minor injury fall.</p> <p>Review of resident #4 ' s Fall CAA (Care Area Assessment) dated 4/12/14 revealed resident #4 had a recent fall, and was unsteady on his/her feet. Resident #4 fell trying to toilet him/herself unassisted and without his/her walker. He/she fell on 3/6/14. Resident #4 was unbalanced and had difficulty moving with assistance and a walker. The resident had multiple diagnoses that could relate to falls.</p> <p>Review of the ADL (activities of daily living) Functional Status CAA dated 4/12/14 revealed resident #4 required assistance with ADLs, bathing, and transfers due to imbalance, the need of assistance, and the use of a walker. Resident #4 had some cognitive loss and communication difficulty. Resident #4 had physical limitations and weakness. He/she used a walker for ambulation due to decreased mobility and bad balance at</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 19</p> <p>times. The resident required the assistance of 1 staff to ambulate and used a four-wheeled walker. The resident required stand-by assistance for transfers and at times required hands on assistance.</p> <p>Review of the quarterly MDS dated 9/29/14 revealed a BIMS score of 12, indicating moderate cognitive impairment. He/she did not exhibit rejection of care. He/she required limited assistance of 1 staff for bed mobility, transfers, walking in the room/corridor, and locomotion on the unit. He/she required supervision with locomotion off the unit. He/she did not have a steady balance and was only able to stabilize with staff assistance. He/she used a walker for mobility. The assessment indicated the resident had not had any falls since prior assessment.</p> <p>Review of resident #4 ' s care plan for falls dated 1/27/14 revealed the resident was at moderate risk for falls related to decreased mobility, walker use, osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density which can lead to an increased risk of fracture), and poor balance. Interventions included to anticipate and meet the resident ' s needs, ensure his/her call light was within reach and encourage the resident to use it for assistance as needed, and he/she needed prompt response to all requests for assistance. The care plan was not reviewed or revised after resident #4 ' s falls on 3/5/14 and 7/8/14.</p> <p>Review of resident #4 ' s care plan for limited physical mobility dated 1/27/14 revealed the resident required 1 staff participation for mobility and he/she used an assistance device of four-wheeled walker for ambulation. The care plan was not revised to reflect resident #4 ' s</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 20 current level of assistance with mobility.</p> <p>Review of an Incident Note Late Entry dated 3/5/2014 at 6:35 p.m. revealed the staff was called to resident #4 's room and the resident was found lying on the floor in front of his/her dresser. Resident #4 had hit his/her head on the corner of the dresser causing a laceration requiring sutures.</p> <p>Review of a Fall Investigation dated 3/5/14 revealed at 6:35 p.m. on 3/5/14 the nurse was called to resident #4's room by the aide. Resident #4 laid on the floor in front of his/her dresser. The resident had hit his/her head on the corner causing a laceration to the top of his/her scalp requiring sutures. The resident reported that he/she got up to go to the bathroom lost his/her balance causing his/her fall. The resident ambulated without assistance using his/her wheeled walker. The resident had just been toileted. The walker had been placed beside the recliner and the resident was in the recliner with blankets on him/her and his/her call light was placed in his/her hand prior to covering the resident.</p> <p>Review of an Incident Note dated 7/8/2014 at 2:08 p.m. revealed resident #4 rolled from his/her bed during the night. He/she had no injuries at the time of the incident. The resident continued to deny pain or any concern.</p> <p>During an observation on 12/3/14 at 2:19 p.m. resident #4 ambulated independently down the hallway towards his/her room with his/her walker and he/she had a steady gait.</p> <p>During an interview on 12/3/14 at 9:37 a.m. direct care staff J reported resident #4 was at risk for</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 21</p> <p>falls. Staff J reported he/she encouraged the resident to use his/her call light. Staff J reported resident #4 often ambulated without staff assistance. Staff J reported if he/she observed resident #4 ambulating without assistance he/she stopped to assist the resident. Staff J reported resident #4 had a shaky balance at times and had difficulty steadying him/herself.</p> <p>During an interview on 12/3/14 at 2:27 p.m. direct care staff I reported he/she was unaware if the resident was at risk for falls. He/she reported interventions to prevent resident #4 from falling included wearing shoes with a non-slip sole and non-slip socks and he/she reported the resident used a walker all the time because at times he/she was very wobbly and the staff encouraged him/her to use that. He/she reported the resident ambulated independently, but did sometimes ask staff to assist him/her. Staff I reported the resident did not need to call for assistance because he/she was independent with transfers. Staff I confirmed on the kardex (electronic care plan accessible to the aides) that resident #4 required 1 staff participation for mobility. Staff I reported 1 staff participation meant 1 aide or staff needed to help resident #4 with whatever the resident needed help with.</p> <p>During an interview on 12/3/14 at 3:53 p.m. licensed nursing staff E revealed resident #4 was at risk for falls. Staff E reported the resident used a walker, transferred and ambulated independently. Staff E reported the intervention to prevent resident #4 from falling included making sure the path between the resident and the bathroom was free of clutter. Staff E reported the staff knew which residents were at risk for falls from the care plan. Staff E reported care plans were updated after falls if there was an</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 22</p> <p>intervention. Staff E was not positive if there was a way to see if the care plan was reviewed after the falls to ensure the care plan included interventions to prevent the fall from recurring.</p> <p>During an interview with administrative nursing staff B on 12/4/14 at 11:59 a.m. revealed prior to November 2014 the facility did not have a system to ensure fall investigations were completed beyond reading the nurse notes, root cause was not identified, or the care plan updated with fall interventions. Staff B reported the staff were not aware of the fall 7/8/14. He/she reported the root cause of the fall on 3/5/14 was determined by the resident to have lost his/her balance and fell. Staff B reported the resident ambulated with a walker and if he/she had far to walk he/she required stand-by assistance. Staff B confirmed resident #4 's care plan was not updated following his/her falls and reported the care plan needed to be updated to reflect that the resident was independent. Staff B reported he/she expected the care plans to be updated following a fall and if the resident had a change in ADL assistance.</p> <p>Although requested on 12/4/14 the facility failed to provide a policy regarding the revision of care plans.</p> <p>The facility failed to review and revise resident #4 's care plan following each fall or revise the care plan to reflect the resident 's level of assistance required for mobility.</p> <p>Review of the resident #21's signed physician orders dated 10/1/14 revealed the following diagnoses: Alzheimers disease (progressive</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
NAME OF PROVIDER OR SUPPLIER ANTHONY COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 212 N 5TH AVE ANTHONY, KS 67003		
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F 280	<p>Continued From page 23</p> <p>mental deterioration characterized by confusion and memory failure)</p> <p>- Review of the comprehensive admission MDS (minimum data set) dated 10/30/14 revealed a he/she had long term and short term memory impairment. The resident's speech clarity was unclear and usually maked him/herself understood by others. This revealed the resident had wandering behaviors. He/she required an assistance of one staff with ADLs (activities of daily living). He/she used a walker for ambulation and residents balance during transfer and walking is steady at all times.</p> <p>Review of the fall CAA (care area assessment) dated 11/4/14 revealed the resident was at increased risk for falls due to his/her dementia diagnosis, hearing and vision deficit as well as the need for assistance with ambulating by using a walker.</p> <p>Review of the ADL/Function CAA dated 10/30/14 revealed the resident ambulated with walker and required assistance with dressing and at times toileting and hygiene.</p> <p>Review of the resident ' s care plan, initiated 10/6/14, revealed to distract the resident from wandering by offering a pleasant diversion, structured activities, food, conversation, television, book. The resident preferred: to sit and visit and possibly watch TV.</p> <p>Review of the resident's care plan, initiated 8/4/14 revealed he/she used a assistive devices walker to ambulate. Staff was to monitor for increased risk for falls.</p> <p>Review of the resident ' s care plan, initiated</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
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F 280	<p>Continued From page 24</p> <p>7/16/14, revealed staff was to ensure that he/she wore appropriate footwear such as shoes and socks or non-skid socks when ambulating.</p> <p>Review of the incident note dated 11/25/2014 at 12:26 AM revealed that staff had removed all socks without grippers due to the 2nd fall while wearing this type of sock on a hard wood floor without shoes.</p> <p>Review of incident note dated 11/13/2014 at 1:12 AM revealed the nurse was coming back from another resident's room and heard the sound of a walker being moved in the resident's room. The staff observed the resident lying on his/her left side on the floor with his/her walker facing him/her. The resident's head was pointed towards the south wall of her room. He/she tried to get him/herself up off the floor. The resident wore regular socks that were slick on the hard wood floor. The resident initially stated he/she fell out of bed but a few minutes later he/she stated they did not fall out of bed and stated he/she had been "twisting and turning and twisting and turning in bed." The resident moved him/herself into a sitting position before a second person arrived to assist in getting him/her off the floor. The resident bore weight, assist and counted 1, 2, 3 as staff lifted him/her up to the bed. The resident did not wear slip gripper socks at the time of fall. Staff obtained a pair of non-slip gripper sock to the resident's feet.</p> <p>Review of the incident note dated 10/22/2014 at 6:51PM revealed staff found the resident kneeling in front of the recliner in his/her room facing the chair. The resident had no red areas or injuries found during assessment.</p> <p>Review of the accident report dated 10/22/14</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 25</p> <p>revealed same information as nursing note and resident #21 wore improper footwear.</p> <p>Interview with licensed nursing staff E on 12/03/2014 at 2:29 PM revealed when a resident had a fall the change plan is changed with the charge nurse and the DON. He/she would not leave his/her socks or shoes on. The care plan did not show that resident did not leave his/her socks or shoes on.</p> <p>Interview with direct care staff I on 12/03/14 at 3:30 PM revealed the resident was confused and the resident needed help with activities of daily living. The resident wandered a lot. Staff often put on a movie or had the resident read newspapers that family had brought when the resident wandered in the facility.</p> <p>Interview with direct care staff K on 12/4/14 at 10:03 AM revealed the resident needed assistance with dressing. He/she often leave the walker behind and wonders if staff can direct him/her into the tv room. The resident sometimes took off his/her shoes and placed the shoes in random places. He/she wore non-skid socks with his/her shoes.</p> <p>Interview with administrative nursing staff B on 12/4/14 at 8:40 AM revealed care plans were updated every quarter, annually, when staff identified falls and significant change. The facility provide non-skid socks for the residents. Staff had just replaced all of his/her with all new non-skid socks. Intervention were placed on the careplan and also on the message board to notify staff of the change. The resident did not like to keep sock or shoes on. Staff B stated that he/she was behind on updating the careplans.</p>	F 280			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 280	Continued From page 26 Review of the facility's policy Comprehensive Care Plans, dated 07/07/2001 revealed resident care plans would be reviewed every 90 days and if the resident experienced a significant change in physical condition. The facility failed to review and revise resident # 21's care plan after his/her fall on 10/22/14.	F 280			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 29 residents with 16 in the sample and 3 reviewed for accidents. Based on observation, interview, and record review the facility failed to initiate the appropriate fall prevention strategies to prevent future falls and properly investigate falls for 2 of 3 residents (#21, #4). Findings included: -Review of the resident #21's signed physician orders dated 10/1/14 revealed the following diagnoses: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) Review of the comprehensive admission MDS	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 27</p> <p>(minimum data set) dated 10/30/14 revealed a he/she had long term and short term memory impairment. The resident's speech clarity was unclear and usually made him/herself understood by others. This revealed the resident had wandering behaviors. He/she required an assistance of one staff with ADLs (activities of daily living). He/she used a walker for ambulation and residents balance during transfer and walking is steady at all times.</p> <p>Review of the fall CAA (care area assessment) dated 11/4/14 revealed the resident was at increased risk for falls due to his/her dementia diagnosis, hearing and vision deficit as well as the need for assistance with ambulating by using a walker.</p> <p>Review of the ADL/Function CAA dated 10/30/14 revealed the resident ambulated with walker and required assistance with dressing and at times toileting and hygiene.</p> <p>Review of the resident's care plan, initiated 10/6/14, revealed to distract the resident from wandering by offering a pleasant diversion, structured activities, food, conversation, television, book. The resident preferred: to sit and visit and possibly watch TV.</p> <p>Review of the resident's care plan, initiated 8/4/14 revealed he/she used a assistive devices walker to ambulate. Staff was to monitor for increased risk for falls.</p> <p>Review of the resident's care plan, initiated 7/16/14, revealed staff was to ensure that he/she wore appropriate footwear such as shoes and socks or non-skid socks when ambulating.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 28</p> <p>Review of the incident note dated 11/25/2014 at 12:26 AM revealed that staff had removed all socks without grippers due to the 2nd fall while wearing this type of sock on a hard wood floor without shoes.</p> <p>Review of incident note dated 11/13/2014 at 1:12 AM revealed the nurse was coming back from another resident's room and heard the sound of a walker being moved in the resident's room. The staff observed the resident lying on his/her left side on the floor with his/her walker facing him/her. The resident's head was pointed towards the south wall of her room. He/she tried to get him/herself up off the floor. The resident wore regular socks that were slick on the hard wood floor. The resident initially stated he/she fell out of bed but a few minutes later he/she stated they did not fall out of bed and stated he/she had been "twisting and turning and twisting and turning in bed." The resident moved him/herself into a sitting position before a second person arrived to assist in getting him/her off the floor. The resident bore weight, assist and counted 1, 2, 3 as staff lifted him/her up to the bed. The resident did not wear slip gripper socks at the time of fall. Staff obtained a pair of non-slip gripper sock to the resident's feet.</p> <p>Review of the incident note dated 10/22/2014 at 6:51PM revealed staff found the resident kneeling in front of the recliner in his/her room facing the chair. The resident had no red areas or injuries found during assessment.</p> <p>Review of the accident report dated 10/22/14 revealed same information as nursing note and resident # 21 wore improper footwear.</p> <p>Observation on 12/03/14 at 1:15 PM revealed the</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 29</p> <p>resident ambulated with walker and had a steady gait with shoes on both feet.</p> <p>Observation on 12/02/14 at 3:05 PM revealed the resident walked with the walker and wore shoes on both feet. The resident ambulated without the walker and left the walker by the cabinet in the dining room. The resident had steady gait as he/she ambulated.</p> <p>Observation on 12/02/14 at 3:11 PM revealed he/she stood up independently from the chair. Staff assisted the resident with getting something to drink.</p> <p>Interview with licensed nursing staff E on 12/03/14 at 2:29 PM revealed when a resident had a fall the care plan is changed with the charge nurse and the DON. He/she would not leave his/her socks or shoes on. The care plan did not show that resident did not leave his/her socks or shoes on.</p> <p>Interview with direct care staff I on 12/03/14 at 3:30 PM revealed the resident was confused and the resident needed help with activities of daily living. The resident wandered a lot. Staff often put on a movie or had the resident read newspapers that family had brought when the resident wandered in the facility.</p> <p>Interview with direct care staff K on 12/4/14 at 10:03 AM revealed the resident needed assistance with dressing. He/she often leave the walker behind and wonders if staff can direct him/her into the tv room. The resident sometimes took off his/her shoes and placed the shoes in</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 30</p> <p>random places. He/she wore non-skid socks with his/her shoes.</p> <p>Interview with administrative nursing staff B on 12/4/14 at 8:40 AM revealed care plans were updated every quarter, annually, when staff identified falls and significant change. The facility provide non-skid socks for the residents. Staff had just replaced all of his/her with all new non-skid socks. Intervention were placed on the care plan and also on the message board to notify staff of the change. The resident did not like to keep sock or shoes on. Staff B stated that he/she was behind on updating the careplans.</p> <p>Review of the facility policy for accidents and incidents, last revised 7/10/14, revealed all accidents or incidents involving residents, employees, visitors vendor, etc., occurring on our premise must be investigated and reported to the administrator.</p> <p>The facility failed to evaluate resident #21 falls for causative factors and develop an individualized plan of care with appropriate fall prevention strategies to prevent future falls.</p> <p>- Review of resident #4 ' s annual MDS (Minimum Data Set) dated 3/29/14 revealed a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. He/she did not exhibit rejection of care. He/she required extensive assistance of 1 staff for bed mobility. He/she required limited assistance for transfers, walking in the room/corridor, and locomotion on/off the unit. He/she did not have a steady balance, but was able to stabilize without staff</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
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F 323	<p>Continued From page 31</p> <p>assistance. He/she utilized a walker for mobility. The assessment indicated the resident had 1 minor injury fall.</p> <p>Review of resident #4 ' s Fall CAA (Care Area Assessment) dated 4/12/14 revealed resident #4 had a recent fall, and was unsteady on his/her feet. Resident #4 fell trying to toilet him/herself unassisted and without his/her walker. He/she fell on 3/6/14. Resident #4 was unbalanced and had difficulty moving with assistance and a walker. The resident had multiple diagnoses that could relate to falls.</p> <p>Review of the ADL (activities of daily living) Functional Status CAA dated 4/12/14 revealed resident #4 required assistance with ADLs, bathing, and transfers due to imbalance, the need of assistance, and the use of a walker. Resident #4 had some cognitive loss and communication difficulty. Resident #4 had physical limitations and weakness. He/she used a walker for ambulation due to decreased mobility and bad balance at times. The resident required the assistance of 1 staff to ambulate and used a four-wheeled walker. The resident required stand-by assistance for transfers and at times required hands on assistance.</p> <p>Review of the quarterly MDS dated 9/29/14 revealed a BIMS score of 12, indicating moderate cognitive impairment. He/she did not exhibit rejection of care. He/she required limited assistance of 1 staff for bed mobility, transfers, walking in the room/corridor, and locomotion on the unit. He/she required supervision with locomotion off the unit. He/she did not have a steady balance and was only able to stabilize with staff assistance. He/she used a walker for mobility. The assessment indicated the resident</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 32 had not had any falls since prior assessment.</p> <p>Review of resident #4 ' s care plan for falls dated 1/27/14 revealed the resident was at moderate risk for falls related to decreased mobility, walker use, osteoporosis (a progressive bone disease that is characterized by a decrease in bone mass and density which can lead to an increased risk of fracture), and poor balance. Interventions included to anticipate and meet the resident ' s needs, ensure his/her call light was within reach and encouraged the resident to use it for assistance as needed, and he/she needed prompt response to all requests for assistance.</p> <p>Review of resident #4 ' s care plan for limited physical mobility dated 1/27/14 revealed the resident required 1 staff participation for mobility and he/she used an assistance device of four-wheeled walker for ambulation.</p> <p>Review of the fall risk assessment dated 12/27/13 revealed a score of 9, indicating resident #4 was at moderate risk for falls.</p> <p>Review of an Incident Note Late Entry dated 3/5/2014 at 6:35 p.m. revealed the staff was called to resident #4 ' s room and the resident was found lying on the floor in front of his/her dresser. Resident #4 had hit his/her head on the corner of the dresser causing a laceration requiring sutures.</p> <p>Review of a Fall Investigation dated 3/5/14 revealed at 6:35 p.m. on 3/5/14 the nurse was called to resident #4's room by the aide. Resident #4 laid on the floor in front of his/her dresser. The resident had hit his/her head on the corner causing a laceration to the top of his/her scalp requiring sutures. The resident reported that</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
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OMB NO. 0938-0391

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F 323	<p>Continued From page 33</p> <p>he/she got up to go to the bathroom lost his/her balance causing his/her fall. The resident ambulated without assistance using his/her wheeled walker. The resident had just been toileted. The walker had been placed beside the recliner and the resident was in the recliner with blankets on him/her and his/her call light was placed in his/her hand prior to covering the resident.</p> <p>Review of a fall risk assessment dated 3/28/14 revealed a score of 7, indicating resident #4 was at moderate risk for falls.</p> <p>Review of a fall risk assessment dated 6/27/14 revealed a score of 9, indicating resident #4 was at moderate risk for falls.</p> <p>Review of an Incident Note dated 7/8/2014 at 2:08 p.m. revealed resident #4 rolled from his/her bed during the night. He/she had no injuries at the time of the incident. The resident continued to deny pain or any concern.</p> <p>Review of the fall risk assessment dated 9/29/14 revealed a fall risk score of 8, indicating moderate risk.</p> <p>During an observation on 12/3/14 at 2:19 p.m. resident #4 ambulated independently down the hallway towards his/her room with his/her walker and he/she had a steady gait.</p> <p>During an interview on 12/3/14 at 9:37 a.m. direct care staff J reported resident #4 was at risk for falls. Staff J reported he/she encouraged the resident to use his/her call light. Staff J reported resident #4 often ambulated without staff assistance. Staff J reported if he/she observed resident #4 ambulating without assistance he/she</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 34</p> <p>stopped to assist the resident. Staff J reported resident #4 had a shaky balance at times and had difficulty steadying him/herself.</p> <p>During an interview on 12/3/14 at 2:27 p.m. direct care staff I reported he/she was unaware if the resident was at risk for falls. He/she reported interventions to prevent resident #4 from falling included wearing shoes with a non-slip sole and non-slip socks and he/she reported the resident used a walker all the time because at times he/she was very wobbly and the staff encouraged him/her to use that. He/she reported the resident ambulated independently, but did sometimes ask staff to assist him/her. Staff I reported the resident did not need to call for assistance because he/she was independent with transfers. Staff I confirmed on the kardex (electronic care plan accessible to the aides) that resident #4 required 1 staff participation for mobility. Staff I reported 1 staff participation meant 1 aide or staff needed to help resident #4 with whatever the resident needed help with.</p> <p>During an interview on 12/3/14 at 3:53 p.m. licensed nursing staff E revealed resident #4 was at risk for falls. Staff E reported the resident used a walker, transferred and ambulated independently. Staff E reported the intervention to prevent resident #4 from falling included making sure the path between the resident and the bathroom was free of clutter. Staff E reported after a resident fell, the nurse, the Director of Nursing, and the Administrator identified the root cause of the fall and updated the care plan. Staff E reported the staff knew which residents were at risk for falls from the care plan.</p> <p>An interview with administrative nursing staff B on 12/4/14 at 11:59 a.m. revealed prior to November</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2014
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F 323	Continued From page 35 2014 the facility did not have a system to ensure fall investigations were completed beyond reading the nurse notes, root cause was not identified, or the care plan updated with fall interventions. Staff B reported the staff were not aware of the fall 7/8/14. He/she reported the root cause of the fall on 3/5/14 was determined by the resident to have lost his/her balance and fell. Staff B reported the resident ambulated with a walker and if he/she had far to walk he/she required stand-by assistance. Review of the facility ' s policy for Accidents and incidents, last revised 07/2014, revealed incidents were reported to the department supervisor as soon as such accident/incident was discovered or when information of such accident/incident was learned. An Accident or Incident Report Form was completed for all reported accidents or incidents. The nurse supervisor/charge nurse and/or the department director or supervisor conducted an immediate investigation of the accident or incident. The completed Accident Investigation Report Form was submitted to the Director of Nursing Services no later than 12 hours after the occurrence of the accident or incident. The facility failed to investigate all falls for resident #4 to identify the root cause of the fall.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 36 nutritional problem.</p> <p>This Requirement is not met as evidenced by: The facility's census totaled 29 with 3 residents sampled for nutrition. Based on observation, record review and interview the facility failed to provide supplements as ordered for 1 of 3 residents at risk for weigh loss (#12)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #12's signed physician's order sheet dated 10/13/14 revealed the following diagnoses: esophageal reflux (backflow of stomach contents to the esophagus). <p>Review of the admission MDS (Minimum Data Set) dated 5/29/14 revealed a BIMS (brief interview of mental status) score of 8 which indicated moderate cognitive impairment. The resident required limited assistance of 1 staff for eating. The resident had a loss of liquids/solids from his/her mouth when eating or drinking, and coughing or choking during meals or when swallowing medications, and complaints of difficulty or pain when swallowing. The resident had a mechanically altered diet, and required a change in texture of food or liquids.</p> <p>Review of the cognitive loss CAA dated 5/29/14 revealed the resident had some cognitive deficit and required cueing and time to answer. The resident had been cognitively intact during the previous assessment and needed assistance adjusting to change. The resident did have total</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 37</p> <p>dependence on staff for much of his/her ADL (activities of daily living) care.</p> <p>Review of the nutritional CAA dated 5/29/14 revealed the resident was overweight. At the time of the assessment the physician did not put the resident on a diet. The resident had swallowing difficulties and was being seen by speech therapy. The resident was on a pureed diet with honey thickened liquids. He/she had a PEG (percutaneous endoscopic gastrostomy) tube (a tube placed into a person 's gastrointestinal system that can be utilized for receiving nutrition and/or medications) in place as well. The resident had a CVA (Cerebrovascular accident - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) resulting in right sided hemiparesis (muscular weakness or partial paralysis restricted to one side of the body). The resident received honey thickened liquids and a pureed diet. The resident required assistance and monitoring with meals.</p> <p>Review of the significant change MDS dated 10/6/14 revealed the resident had a BIMS score of 14 which indicated cognitively intact. The resident required staff supervision/set up for meals. The assessment revealed he/she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The resident was not on prescribed weight-loss regimen.</p> <p>Review of the resident's care plan last revised 06/06/14 revealed the resident had difficulty swallowing due to right sided hemiparesis, and staff were to monitor for choking. The resident was to avoid lying down for at least 1 hour after eating and staff were to keep the head of the bed elevated and encourage the resident to stand</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/10/2014
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F 325	<p>Continued From page 38</p> <p>upright after meals. Staff were to assist the resident to avoid foods or beverages that tend to irritate esophageal lining such as; alcohol, chocolate, caffeine, acidic or spicy foods, and fried or fatty foods. All staff were to be informed of the resident 's special dietary and safety needs. The resident took the medications Omeprazole, and Reglan for gastric reflux prevention.</p> <p>An intervention to the Care Plan was added on 9/16/14 that indicated the resident could have regular foods. Staff were to notify the charge nurse if the resident exhibited choking.</p> <p>An intervention to the Care Plan was added on 11/20/14 that indicated the resident should receive Boost supplement shakes three times daily.</p> <p>Review of the physician orders dated 6/23/14 revealed the resident should receive a regular diet with puree consistency and honey thickened liquids.</p> <p>Review of the physician orders dated 6/23/14 revealed the resident was to have health shakes three times daily.</p> <p>Review of the medication administration record from 6/23/14 to 10/6/14 revealed the health shakes were on hold. No order was found for them to be on hold and the shakes were not added to the care plan until 11/20/14.</p> <p>Review of the physician orders dated 9/18/14 revealed the resident's diet changed to a regular diet with pureed texture and thin liquids.</p> <p>Review of the clinical record revealed a</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 39</p> <p>physician's order dated 10/6/14 for health shakes three times daily. Review of the MAR revealed the health shakes were given as ordered after 10/6/14.</p> <p>Review of the resident's weights revealed:</p> <p>Date- 06/27/14 174 lbs (pounds) Date- 07/23/14 158 lbs Date- 08/25/14 163 lbs Date- 09/24/14 166 lbs Date- 10/20/14 166 lbs Date- 11/21/14 168 lbs Date- 12/03/14 172 lbs</p> <p>A total weight loss from 6/27 to 7/23 of 9.2% weight loss in one month.</p> <p>Review of the registered dietician note dated 6/20/14 revealed the resident did not accept pureed foods per nurse 's notes and CNAs (certified nurse aides). Staff encouraged the resident to take pureed foods. Nutritional needs for the resident included; 1650-2040 calories, 1650-2040 milliliters of fluid and 55-68 grams of protein.</p> <p>Review of the registered dietician note dated 6/24/14 revealed the resident had returned from the hospital on 6/23/14 with a weight of 161.2 lbs, which was down 23.4 lbs since going in to the hospital. Also the resident ' s diet had been modified to a puréed diet with thickened liquids. The resident did not like the thickened liquids, but did okay with the puréed texture at the first meal back at the facility.</p> <p>Review of the registered dietician note dated 7/7/14 revealed the resident required supplements due to poor meal intake of pureed</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 40</p> <p>diet with honey thick liquids. Staff encouraged the resident to eat. The resident could make his/her food preferences known.</p> <p>Review of the registered dietician's progress note dated 11/30/14 revealed the resident had a weight increase of 7.5%. The resident had a history of weight variances with diuretic medication use. The resident was independent for feeding himself/herself and received regular pureed meals. The resident was at risk for inadequate fluid intake related to total care for ADLs, diuretic use, laxative use, and difficulty swallowing with a history of tube feeding, and depression. The resident required increased protein needs and was at risk for skin breakdown related to a history of buttocks sores, incontinence, and weight loss. The resident received nutrition shakes per orders. Staff encouraged the resident to eat well. Nutritional needs for the resident were; 1650 calories with 55 grams of protein and 2,366 milliliters of water daily. The dietician recommended a regular pureed diet with PEG tube flushes and shakes to continue as ordered.</p> <p>During an observation on 12/4/14 at 8:25 AM revealed the resident ate a breakfast of sausage gravy with a biscuit, 2 bacon strips, applesauce, water, and juice. The resident consumed 100% of the breakfast.</p> <p>An interview on 12/3/14 at 7:52 AM with the resident revealed the food quality had decreased at the facility and he/she received a lot of chicken and Mexican foods. He/she reported he/she did order alternatives and the staff would fix anything he/she wanted. He/she reported he/she did receive the Breeze health shakes three times a day for nutrient value and has been receiving</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 41 them since he/she came to the facility.</p> <p>An interview on 12/3/14 at 11:49 AM with direct care staff H revealed he/she did not know the resident had ever had any weight loss. Staff reported the resident had a puree diet but did not like it, and the resident received thin liquids.</p> <p>Interview on 12/04/2014 at 11:23 AM with administrative nursing staff B revealed the facility did not do any preventative care to prevent weight loss. Staff B was aware of the weight changes for resident # 12. Staff B reported he/she was responsible for monitoring the residents' weights and updating the care plans, as well as implementing interventions for weight loss. The staff were aware of resident # 12 ' s weight changes and were documenting. Some of the residents received fortified foods. Staff B reported resident #12 received a pureed diet with thick liquids and that the resident did not like the food consistency and would not eat very much. Staff B reported the resident also received supplements three times daily.</p> <p>Interview on 12/04/2014 at 10:23 AM with licensed nursing staff E revealed the resident had been admitted to the facility with a pureed diet, and the resident did not like the pureed diet. Staff were not giving any supplements through the peg tube. The resident had progressed to eating solids since around October, with thin liquids. Staff E reported if a resident had a weight loss the resident would be seen by the physician, and it would be included in the care plan meetings.</p> <p>During an interview on 12/04/14 at 5:00 PM with dietary management staff D revealed the staff did not use a breakout menu of calories and nutrition. Staff D could not ensure that residents were</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	<p>Continued From page 42</p> <p>getting enough nutrition. Staff D reported he/she assisted with the tracking of the resident ' s weights. Staff D reported staff checked the residents ' weights weekly. A change of 2-3% in weight would be reported to the Director of Nursing. Staff D reported the facility did not have fortified or therapeutic foods or diets. Staff D did not know what was considered a fortified food. Staff D reported that when the registered dietician rounds in the facility, he/she made recommendations for supplements, and staff D ordered the health shakes and resource juice supplements. Nutritional assessments were done quarterly. Staff D reported not all resident weights were monitored weekly. Staff D reported resident #12 did not like thinned liquids or pureed foods. The resident required assistance with feeding and would not help himself/herself. He/she verified that no supplements had been placed on the care plan until recently and that the nursing staff gave supplements. Staff D was aware of the resident ' s weight loss, but reported the resident was not at risk due to being over his/her ideal body weight. Interview on 12/8/14 at 10:28 AM with administrative nursing staff B revealed the order for supplements had been resumed on 6/23/14 when the resident returned from the hospital. Staff reported the resident did receive supplement shakes after his/her return from the hospital, but there was no documentation to show that he/she received them. Staff B reported that on the electronic MAR, the order was not documented due to the order being placed on hold instead of resumed. This continued until a second order was written on 10/6/14.</p> <p>During an interview on 12/8/14 at 12:15 PM physician O reported he/she had been made aware the resident had weight loss. Physician O reported the resident had orders for a nutritional</p>	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 325	Continued From page 43 supplement to prevent further weight loss. The physician was not aware the resident had not been receiving the supplements from 6/23/14 to 10/6/14. The facility failed to provide nutritional supplements to prevent weight loss for resident #12.	F 325			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 29 residents. Based on observation, interview, and record review the facility failed to ensure proper holding temperatures for food on the steam table. Findings included: - An observation on 12/3/14 at 11:04 a.m. dietary staff L measured the temperature of barbecue pulled pork on the steam table. He/she obtain a temperature of 125 degrees Fahrenheit (F). Staff L reported he/she liked to have holding temperatures of 160 degrees F, but resident's at times complained that was too hot so he/she turned the temperature down as needed. Staff L began to plate the pulled pork onto plates for residents. The surveyor alerted staff L the danger	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 44</p> <p>zone temperatures for food items on the steam table were between 41 degrees F and 135 degrees F. Staff L reported since he/she had just placed the pulled pork onto the steam table from the oven the steam table likely had not reached its temperature so he/she would wait to serve any more pulled pork until it reached the temperature.</p> <p>On 12/3/14 at 11:29 a.m. staff L measured the temperature of the pulled pork and obtained a temperature of 120 degrees F. Staff L reported that he/she would turn the temperature up on the steam table and see what that did.</p> <p>On 12/3/14 at 11:37 a.m. staff L measured the temperature of the pulled pork and obtained a temperature of 120 degrees F. He/she called dietary staff F for assistance.</p> <p>On 12/3/14 at 11:43 a.m. dietary staff F reported the holding temperature of the pulled pork should be between 135-145 degrees F. Staff F instructed staff L to put the pulled pork on the stove on low heat and bring it up to temperature or put it in a bowl and microwave it for each order but he/she would need to measure the temperature each time it was taken from the microwave. Staff F reported the dietary staff were trained on appropriate holding temperatures when they were hired or if the staff required additional assistance he/she worked with them. Staff F confirmed that staff L should have reheated the pulled pork when a holding temperature of 125 degrees F was obtained.</p> <p>On 12/3/14 at 11:55 p.m. staff L measured the temperature of the pulled pork while he/she heated it on the stove and he/she obtained a temperature of 140 degrees F.</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 45 Although requested on 12/4/14 the facility failed to provide a policy regarding food holding temperatures. The facility failed to ensure food on the steam table was in acceptable temperature ranges prior to service to residents to prevent food-borne illness.	F 371			